Georgia Department of Public Health
Tuberculosis Unit

Client referral form

CONTACT INFORMATION

Name________________________DOB_______________SSN_______________Race____Gender _______
Current address____Phone_____________________
Grade completed __________Language__________________________Birthplace____________________
Current living situation: ____
____
Marital status/Significant other: Married Singled Divorced Widowed
Name:___________________________Address/phone ____
____

EMERGENCY CONTACT

Next of kin: Name___________________________Address/phone _______________________________

Relatives/friends (name, relationship, contact)
____
____
____
____

INSURANCE INFORMATION

Medicaid:____________________________Medicare:______________Self-Paid:_______________Private Insurance:________________________others: ____________________veteran:________________________

SOURCES OF INCOME

Employed (name of employer)	Unemployed (dates)	Source of income (SSI, relatives..)

CURRENT SERVICES

Agency (names, dates)	Type of service received

MENTAL HEALTH HISTORY

Date diagnosed:	Diagnosis:

DRUG/ALCOHOL HISTORY

Date diagnosed:	Last time used:

LEGAL HISTORY

Date of last incarceration:	Reason:

Developed by Djatou Coulibaly LMSW 10/25/11

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DOMESTIC VIOLENCE (PHYSICAL ABUSE/SEXUAL ABUSE/NEGLECT)	
Date of last episode:	By whom:
OTHER ISSUES PLEASE LIST:	
PRESENTING ISSUE: WHY IS CLIENT BEING REFERRED?	
TB STATUS/MEDICATIONS: **When no more infectious:** **When treatment started:** **When treatment will end:** **When referred to ALA:** **Last day with ALA:**	
OTHER HEALTH ISSUES:	
CLIENT REFERRED BY: ________________________________ **DATE OF REFERRAL**________________ **EMAIL:** ___________________________________ **PHONE:** ________________________________	